NOTICE OF INDEPENDENT REVIEW DECISION

December 9, 2002

RE: MDR Tracking #: M2-03-0275-01
IRO Certificate #: 4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ___ physician reviewer who is board certified in orthopedic surgery which is the same specialty as the treating physician. The ___ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 45 year old male sustained a work-related injury on ___ when he injured his back. An MRI dated 11/12/01 revealed L4-5 posterior central 3mm discal protrusion with impingement on the anterior thecal sac and evidence of posterior central annular tear. The treating physician has recommended that the patient undergo a bilateral lumbar laminectomy and discectomy at L4-5.

Requested Service(s)

Bilateral lumbar laminectomy and discectomy at L4-5.

Decision

It is determined that the bilateral lumbar laminectomy and discectomy at L4-5 is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

While some of the medical record documentation supports the diagnosis of radiculopathy, it does not support the diagnosis of nerve root involvement. The presence of nerve root pressure that would be confirmed by a myelogram/CT scan is not presented in the medical record documentation. The MRI as recorded does not support the necessity for the proposed surgical intervention. Therefore, the bilateral lumbar laminectomy and discectomy at L4-5 is not medically necessary at this time.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (10) days of your receipt of this decision (20 Tex. Admin. Code 142.5 (c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,